

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 7-9-01.
- b. The request was received on 7-2-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60
 - b. HCFA
 - c. EOB
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC-60
3. The Commission requested two copies of additional documentation via a Fee Letter (MR 116) that was mailed to the Requestor on 7-31-02. The Requestor did not respond as required by Rule 133.307 (g) (3). Therefore, the Commission could not forward any additional documentation to the Respondent per Rule 133.307 (g) (4). The Respondent's three (3) day response is reflected in Exhibit II of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: No position statement noted in the dispute packet.
2. Respondent: No position statement noted in the dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 7-9-01.
2. The Carrier has denied the dispute date of service as, "Z – TREATMENT OR SERVICE PROVIDED REQUIRED PREAUTHORIZATION. PREAUTHORIZATION WAS REQUESTED BY THE HEALTH CARE PROVIDER AND DENIED, THEREFORE, THE TREATMENT OR SERVICE IS NOT REIMBURSED."

3. During a phone conversation with the provider's office on 11-26-02, Provider rep. indicated that the Carrier had made a payment of \$36.00. The remaining balance in dispute was \$72.00.
4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
7-9-01	95851 x 3	\$108.00	\$36.00	Z	\$36.00	TWCC Rule 134.600; CPT Descriptor	The Carrier has denied the dispute service as "Z". CPT Code 95851 does not require preauthorization. Therefore, reimbursement is recommended in the amount of \$72.00.
Totals		\$108.00	\$36.00				The Requestor is entitled to reimbursement in the amount of \$72.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **\$72.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3rd day of December 2002.

Lesia Lenart
Medical Dispute Resolution Officer
Medical Review Division

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